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August 28, 2014

VIA EMAIL & FEDEX

Mr. Kevin McDonald
Chief, Certificate of Need
Health Facilities Coordination Office
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Talbot Hospice Foundation – Certificate of Need Application – Response to 8.25.14 Inquiry

Dear Mr. McDonald:

Enclosed, please find six (6) copies of Talbot Hospice Foundation's response to the questions set forth in your letter of August 25, 2014. Please let me know if this response is satisfactory, or if instead you have additional questions or concerns

Your attention is appreciated.

Respectfully Submitted,

Jonathan Montgomery

Enclosures

cc: Suellen Wideman, Esq. (w/o enclosures)
Kathleen H. Foster, R.N., M.S. – Health Officer, Talbot County Health Department (with enclosures)
Mr. Michael Tooke (with enclosures)
Ms. Julie Crocker (with enclosures)

TALBOT HOSPICE FOUNDATION, INC.:

RESPONSE TO REQUEST FOR ADDITIONAL INFORMATION

QUALITY

1. In 2009, a survey by the Office of Health Care Quality (OHCQ) found deficiencies that appear to indicate an organizational culture in which Talbot Hospice Foundation persisted in working outside the scope of its limited license, with individual staff members working outside their scope(s) of practice. Please provide the dates and results of any subsequent survey findings (standard or complaint-related surveys) by OHCQ during the period in which the Guest House was operated as a limited license hospice or during the period in which it has operated as a licensed assisted living facility.

Talbot Hospice Foundation, Inc. ("**Talbot Hospice**") has long maintained a residence (the "**Guest Wing**") for members of the Talbot County community nearing the end of life. As a limited hospice care program, Talbot Hospice offered at the Guest Wing volunteer, bereavement, and support services to residents in coordination with Shore Home Care and Hospice ("**Shore**").

In that regard, Talbot Hospice has been an important part of Talbot County hospice care for decades. The Guest Wing has historically filled in the gaps in care and provided resources to Talbot County hospice patients who otherwise would lack substantial support. The 2009 survey referred to above raised a concern that Talbot Hospice's certified nursing assistants (CNAs) provided care without adequate supervision by either Shore's nursing staff or by any other registered nurse empowered to act as a delegated nurse for the CNAs. This concern arose only after Board of Nursing policy changed to increase supervision requirements. Talbot Hospice's staffing plan was compliant when adopted: Talbot Hospice cleared with the Board of Nursing the specific issue of delegation of nursing acts, as reflected on page 4 (subsection 9) of a 1998 letter from the Board to Talbot Hospice (enclosed as Exhibit A). And the Guest Wing had been in operation for 11 years prior to 2009 without any compliance issues.

Talbot Hospice's response to the 2009 survey similarly exhibited an organizational culture of compliance and dialogue with regulators. Talbot Hospice asked for dialogue with OHCQ to resolve OCHQ's concerns, as reflected in an April 27, 2009 letter from OHCQ to Talbot Hospice (enclosed as Exhibit B). As the letter shows, Talbot Hospice entered a plan of correction, and no further licensure action was pursued. OHCQ commented upon Talbot Hospice's "unique history…and its established record of care" and thanked Talbot Hospice for its "thoughtful response."

Today, the Guest Wing is an assisted living facility. Talbot Hospice is thus authorized to provide on-site nursing under the supervision of a delegating nurse.[1] On December 17, 2013, OHCQ conducted a pre-licensure survey to determine Talbot Hospice's compliance with Maryland regulations applicable to assisted living facilities. As shown in the enclosed Exhibit C, this survey verified Talbot Hospice's compliance. No deficiencies were found.

Additionally, on August 3, 2011, OHCQ completed a complaint-related survey. As shown in the enclosed Exhibit D, OHCQ found that the complaint was not substantiated; OHCQ identified no deficiencies related to the complaint. Notably, this is the *only* complaint-related survey of the Guest Wing since it opened over fifteen years ago.

In 2014, OHCQ has not performed any surveys of Talbot Hospice, whether complaint-related or standard. Talbot Hospice is in full compliance with its licenses. It is not performing any service beyond the scope of its licenses.

BUDGET AND VIABILITY

2. The revenue and expense schedule (Table 4) shows "inpatient" revenue and footnotes this revenue as a "pass-through" of Medicare income Talbot Hospice Foundation would receive for inpatient care provided to its hospice patients in other health care facility settings, all of which would be used to pay those facilities for the general inpatient care provided for Talbot Hospice residents. Thus this pass-through should also be reflected as an expense; which expense line in Table 4 includes this pass-through revenue?

The expense line "Contractual Services" – Line 2(b) of Table 4 – reflects the expense associated with the pass-through inpatient revenue identified in Line 1(a) of Table 4.

3. The revenue and expense projections in the CON application excerpted below show a heavy reliance on philanthropy and investment earnings to subsidize operational losses in the provision of general hospice services.

	2015	2016	2017	2018
Net patient services revenue	$1,399,046	$1,578,363	$1,757,679	$1,936,998
Total operating expenses	$1,871,462	$1,953,728	$2,036,628	$2,120,179
Income from operations	($472,416)	($375,365)	($278,949	($183,181)
*Other operating income**	*$300,000*	*$306,900*	*$313,959*	*$321,180*
Total	($172,416)	($68,465)	$35,010	$137,999

* Specified by applicant as endowment income and donations

[1] *See* COMAR 10.07.14.14(E)(1).

a. Why is this revenue identified as "operating" income? Wouldn't it be more correctly identified as "non-operating" income?

Talbot Hospice counted donations and endowment income as "operating income" for two reasons.

First, as an accounting concept, "operating income" is typically defined as recurring income related to the typical activities of an organization.[2] All non-profit hospice services attempt to raise money from donations. Talbot Hospice is a non-profit organization; for the past thirty years, it has regularly engaged in substantial development activities to produce a predictable, steady stream of donations and endowment income.

Second, if "operating income" were limited to revenue from health care services, then Line (1)(i) of Table 4 would be redundant. That is, Line (1)(g) of Table 4 already calls for "net patient services revenue" of the hospice project. Line (1)(i) must then include revenue beyond "patient services revenue." Therefore, Talbot Hospice included donations and endowment income in "other" operating revenues, together with a notation describing the nature of the income. Talbot Hospice also included the salary, wage, and benefit expenses for development personnel in Line 2(a) of Table 4, amounting to $112,147.

That said, Talbot Hospice has no objection to the Commission labeling donations and endowment income "non-operating income" while also excluding the development personnel expenses identified above.

b. Does Talbot Hospice expect that its proposed general hospice operations will ever become self-sustaining? If so, how many years is that expected to take? If not, please speak to the long-term sustainability of a program reliant on philanthropic income over the long term.

Not only can Talbot Hospice's hospice project sustain itself, but it can do so robustly.

In Table 4 of its application, Talbot Hospice conservatively projected hospice need for 2016 at 137 deaths, for a total patient load of 201 patients over the course of the year, and an average daily census of 29 patients. This projection shows growth in hospice net income from 2015 to 2018 of about $100,000 per year. Extending this conservative projection out additional years, Talbot Hospice's hospice operations – excluding donations and endowment income and development staff expense – will achieve a financial surplus by about 2019 (as shown in the enclosed Exhibit E). That is, in 2019, "net patient services revenue" (Line (1)(g) of Exhibit E) will exceed "total operating expenses" for the project (Line (2)(k) of Exhibit E).

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[2] *See, e.g., Operating Revenue Definition*, Investopedia, http://www.investopedia.com/terms/o/operating-revenue.asp (last visited August 28, 2014).

Using the Commission's hospice volume assumptions for Talbot County, Talbot Hospice would break even (excluding donations and endowment income) even faster. In April of 2013, the Commission projected that 2016 hospice need for Talbot County would amount to 188 deaths (projections enclosed as Exhibit F). This is 51 more than Talbot Hospice conservatively projects, and translates into 2,550 additional patient days. Although more patient days mean additional costs, the increased revenue associated with those days would accelerate Talbot Hospice's growth in net income.

That said, nonprofit hospices do regularly rely on philanthropy; Talbot Hospice is not an outlier. As a nonprofit, Talbot Hospice believes that its endowment and donation income is quite sustainable. As reflected in its (previously submitted) FY 2013 financial statement, Talbot Hospice maintains an endowment of over $5,000,000 for the Guest Wing and Talbot Hospice's hospice operations. The endowment income alone covers any projected shortfall. This endowment and regular donation stream reflects a 30 year history of generating community support income through memorials, contributions and events involving not only patients and their families, but also the whole community. Talbot Hospice's unique, established financial strength will sustain this hospice project.

c. The Medicare Payment Advisory Commission recommended that Congress eliminate the update to the hospice payment rate in fiscal year 2014 and in the upcoming fiscal year, finding that existing Medicare rates are, generally, providing hospices with a healthy margin and access to capital. If Talbot Hospice Foundation does not project the ability to generate income from the provision of hospice patient care, why should MHCC authorize creation of a hospice that cannot sustain itself with operating revenues, given the level of profitability being achieved throughout this care sector? Shouldn't the residents of Talbot County be able to obtain hospice services from a program that can cover its costs with the third-party payor revenue generated from insurance premiums and payroll taxes without requiring further financial support in the form of philanthropy?

As described above, Talbot Hospice will not require philanthropic support for its basic hospice operations. In any event, the general trend in profitability described by the MedPAC report does not fit the particular circumstances at issue here.

First, the same MedPAC report referred to above also points out that non-institutional, nonprofit, and rural hospices have not shared in the general increase in profitability.

The MedPAC report is careful to note that rural hospices are disadvantaged. "Overall, hospices in urban areas have a higher aggregate Medicare margin (9 percent) than those in rural areas (6.2 percent)."[3] It is no surprise therefore that "the number of hospices located in rural

[3] Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2014, p. 315, *available at* http://www.medpac.gov/documents/mar14_entirereport.pdf. [hereinafter, *MedPAC Report*.]

areas has declined modestly since 2007."[4] Other research explains the reasons for this disparity: "Medicare per diem rates are consistently lower for rural hospices" due to wage indexing even though "other differences in costs…may be significantly higher for rural hospices, such as travel to patients' homes."[5]

The MedPAC report also points out that the "Medicare margin was considerably higher for for-profit hospices (14.5 percent) than for nonprofit hospices (2.5 percent)."[6] Hospice growth over the last decade is attributable to for-profit hospice. "For profit hospices account almost entirely for the growth in the number of hospices" and in recent years "the number of nonprofit hospices was relatively flat."[7] For-profit hospices generate these margins by longer length of stay; the average length of stay found by MedPAC for such hospices was 105 days, as opposed to 69 days for nonprofits, a difference of thousands of dollars in per-patient revenue.[8]

A recent report prepared by request of CMS summarized these trends as follows:

> "[C]haracteristics associated with higher profit margins include hospices that are above cap, larger, freestanding, for profit, and that operate in an urban setting. Smaller hospices and hospices in rural settings tend to have higher per diem costs and likely lower payments from Medicare, a combination that leaves these types of facilities at a financial disadvantage."[9]

Indeed, while MedPAC did propose suspending the 2014 and 2015 Medicare hospice payment updates, it did so in the context of recommending reforms to Medicare to redistribute payments *between* hospices such that the nonprofit, rural hospices may see an *increase* in hospice payments even as Medicare hospice expenditures flatten. "Modifying the payment system would help make payments more equitable across providers, decreasing payments to providers who have disproportionately long stays and high margins and increasing payments to providers who have shorter stays and lower margins."[10]

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[4] *MedPAC Report*, p. 307.

[5] Casey, M., et al. "Providing hospice care in rural areas: challenges and strategies." *American Journal of Hospice and Palliative Medicine* 22.5 (2005): 363-368.

[6] *MedPAC Report*, p. 315.

[7] *MedPAC Report*, p. 306.

[8] *MedPAC Report*, p. 309 (Table 12-5: Hospice length of stay among decedents by beneficiary and hospice characteristics, 2012).

[9] Razaee, M. et al. "Medicare hospice payment reform: A Review of the literature (2013 Update)." (Abt Associates, Inc., May 2014), p. 41, *available at*: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Downloads/MedicareHospicePaymentReformLiteratureReview2013Update.pdf

[10] *MedPAC Report*, p. 304

Second, Talbot Hospice's projected costs reflect its commitment to continue to provide services and resources to hospice patients beyond the bare minimum required under federal and Maryland regulations. In particular:

• Pre-Hospice Support. As described in previous submissions, Talbot Hospice offers "Pathways" - a pre-hospice program that provides non-medical support to Talbot County residents with currently progressing life-limiting illness who choose to continue life-extending or curative treatments. The program provides a nurse educator, bereavement counseling, spiritual counseling, volunteer support, light durable medical equipment, and supplies. Hospice staff involved with Pathways meet every two weeks as an interdisciplinary group to coordinate services for each patient and family in the program. The Pathways program has always been provided to patients and families without charge.

• Extensive Volunteer and Bereavement Services. Talbot Hospice supports a volunteer corps of over 300 individuals (in a community of 38,000), far in excess of any state or federal requirement. Volunteers are not just mowing lawns; specially trained end-of-life doulas are provided to patients in the last 48 hours.

Moreover, Talbot Hospice provides a broad array of bereavement and spiritual counseling, all without charge to any patient or community group. A "Caregivers Support" group meets weekly and is open to anyone who is caring for a loved one with a life limiting illness, regardless of any prior or current enrollment in a formal hospice benefit. The "Suicide Grievers Support Group" and the school-based "Rainbow Days" are other examples of end-of-life related support services that are open to anyone in the community. Bereavement support is offered prior to death through "Looking Ahead" classes while classes in the "Next Chapter" program are for persons moving on from grief. Both groups are open to anyone in the community, irrespective of any previous relationship with Talbot Hospice.

In this regard, please note that bereavement services are unfunded mandates under Medicare and not accounted for in MedPAC's margin calculations. The Social Security Act "requires that hospices offer bereavement services to family members of their deceased Medicare patients" but at the same time "prohibits Medicare payment for bereavement services."[11] Non-core volunteer services are mandated, but not funded by Medicare.[12] Talbot Hospice plans to continue to service Talbot County above and beyond federal and Maryland requirements.

• Support for Daily Living. Since the opening of The Guest Wing in 1998, room and board were provided without charge to residents until 2011, when a sliding fee scale was introduced for those residents who are able to bear some of the room and board costs. Under the

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[11] *MedPAC Report*, p. 315.

[12] *MedPAC Report*, p. 315.

current sliding scale, the maximum daily fee represents only 50% of the actual costs of room and board. Talbot Hospice receives no reimbursement for residential services from any payer.

- Supererogatory Items. Talbot Hospice provides supplies to patients and families enrolled in the Pathways program based on financial need. These supplies include items such as disposable pads, wipes, gowns, gloves, barrier creams, and light durable medical equipment. Talbot Hospice receives no reimbursement for providing these supplies, and provides them to patients without charge. The letters of support for this application reflect the variety of experiences with Talbot Hospice charity care and community outreach, above and beyond requirements.

Simply put, Talbot Hospice does more with less.

d. What other programs of Talbot Hospice Foundation will continue to need subsidization? List these programs and outline the level of support they will require.

Talbot Hospice will continue to operate the Guest Wing. Talbot Hospice offers substantial charity care through the Guest Wing, and maintains dedicated endowment funds and donation streams dedicated to the Guest Wing. The Guest Wing has historically required about $225,000 per year from donations and endowment income.

AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

4. In response to this criterion, Talbot Hospice Foundation has described a situation in Talbot County wherein the existing provider (Shore Home Care and Hospice) is withdrawing from providing hospice services via a proposed sale of its hospice assets to Hospice of Queen Anne's (HQA), expanding HQA's authorization into Talbot and Caroline Counties. This proposed transaction would occur on the heels of HQA's recent acquisition of the hospice assets of Chester River Home Care and Hospice. In that transaction, as well as its pending acquisition of Shore Home Care and Hospice, HQA stated that those consolidations were in the public interest because they brought economies of scale to the delivery of hospice services.

However, under the terms of that proposed transaction, HQA agreed to a provision obligating it to cease providing services in Talbot County if and when Talbot Hospice Foundation ("Talbot Hospice") becomes ready to assume the role of a general hospice by getting CON approval and becoming licensed. HQA has stated that it "would have preferred" to continue serving Talbot County but was agreeing to withdraw in order to "maintain a collegial relationship with Talbot Hospice."

Thus one possible alternative scenario would be for HQA to continue as a general hospice provider in Talbot County following its acquisition of the hospice assets of Shore Home Care and Hospice.

Please describe why approving Talbot Hospice, which will trigger withdrawal of HQA from the jurisdiction, is a more cost-effective alternative than simply allowing HQA to expand into Talbot County, realizing further economies of scale in its operation.

Hospice of Queen Anne's, Inc. ("**HQA**") is not a more cost-effective alternative to Talbot Hospice, for multiple reasons.

First, as described above, Talbot Hospice will become sustainable (excluding philanthropy) by 2020, even under conservative volume assumptions.

Second, Talbot Hospice is not aware of anything entered in the record of this certificate of need process showing that HQA would be able to operate sustainably in Talbot County, even excluding the broad array of additional services Talbot Hospice traditionally provides. Talbot Hospice is not aware of any data or estimates showing, for instance, what HQA's Talbot County expenses and revenues would be on a long term basis. HQA has indicated in writing to the Commission that it will surrender any Talbot County authorization once Talbot Hospice becomes operational. This alternative appears entirely counterfactual and hypothetical.

Third, Talbot Hospice has reason to believe that it is more cost effective.

HQA has informed Talbot Hospice that HQA would operate at a loss in Talbot County. There may be a deficit between third-party reimbursement for hospice services rendered by HQA and HQA's actual cost of providing such services. Therefore, HQA requested (and is receiving) a subsidy from Talbot Hospice for interim services in Talbot County to reflect increased incremental costs to HQA for serving Talbot County. This subsidy amounts to **$25.00** per census day up to an average of **$555.56** per day total. For instance, if HQA provides services in Talbot County for six months, then HQA could receive a subsidy of up to $100,000.

HQA also represented that it would need to hire and train new personnel for Talbot County. To induce HQA to make these new hires, Talbot Hospice will pay HQA for those new hires who transfer to Talbot Hospice, in the amount of $6,240 per RN, $3,120 per CNA, $7,920 per social worker, and $7,200 per grief counselor. This is in addition to the subsidy mentioned in the previous paragraph.

Fourth, community-based hospice care programs – such as HQA and Talbot Hospice – realize few economies of scale. "Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure."[13] Direct patient care staff – the bulk of hospice personnel[14] – is variable cost; a nurse's case load can only grow so large.[15]

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[13] *MedPAC Report*, p. 300.

[14] National Hospice and Palliative Care Organization. "NHPCO's Facts and Figures: Hospice Care in America." (2013), p. 11, *available at* http://www.nhpco.org/sites/default/files/public/Statistics_Research/2013_Facts_Figures.pdf ("70.4% of home hospice full-time equivalent employees (FTEs) were designated for direct patient care or bereavement support in 2012").

Other administrative costs (e.g. administrative salaries) are net neutral as between HQA and Talbot Hospice. For instance, Talbot Hospice already has an executive director and an administrator. In other words, the ongoing administrative costs for this hospice project are not necessarily *incremental* increases in *actual* cost to Talbot Hospice or the health care delivery system.

Fifth, Talbot Hospice is uniquely suited to serve Talbot County because the community simply demands that Talbot Hospice remain prominent in hospice in Talbot County. The most persuasive evidence of this can be found in the hundreds of letters written in support of this application. These letters came from the widow who remembers the loving care her husband received in his final days, from community leaders such as the President of the Chamber of Commerce, and from health care leaders such as the President of the Shore Health Board of Directors. The letters include strong statements from Easton and Talbot County councils recognizing the fundamental contribution that Talbot Hospice makes to the quality of life in the community. The Commission should take into consideration the growing anticipation in Talbot County that its locally managed hospice – the hospice it knows and the hospice it operates – will soon become the general hospice care program serving the community.

Sixth, Talbot Hospice has an exceptional **$5,000,000** endowment to provide hospice care. Talbot County residents and patients built this endowment through gifts specifically designating Talbot Hospice as the recipient, demonstrating the strength and specificity of donors' connection to Talbot Hospice. Talbot Hospice is not aware of HQA's level of philanthropic support, if any, in Talbot County or elsewhere.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Signature:

Printed Name: Michael C. Tooke, M.D.

Date: August 28, 2014

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[15] For example, "[i]n 2012, the average patient caseload for a hospice aide was 11.0 patients"). *Id.* p. 12.

EXHIBIT A

STATE OF MARYLAND

4140 PATTERSON AVE.
BALTIMORE, MARYLAND 21215

410-764-5124 585-1900
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MARYLAND BOARD OF NURSING

May 20, 1998

Liz Freedlander
Executive Director
Talbot Hospice Foundation, Inc.
216 South Street
Easton, MD. 21601

Dear Ms. Freedlander:

Thank you for your letter of April 22, 1998 in which you summarized an informal discussion held on April 17, 1998 between yourself, Donna Stone, Home Health Aide, Gail Woodall, RN, and this consultant.

During this informal discussion the framework for the Talbot Hospice Foundation to provide hospice care under a limited hospice license through the Licensing and Certification Administration was discussed. At that time you stated that Hospice House would provide twenty four hour residential care to individual clients; the care would be provided by volunteer caregivers who would be considered surrogate family members/significant others; and, there would be no charge to the client for Hospice House Care. You stated that the criteria for admission to Hospice House would be:

1. Clients considered for admission would be those with a terminal diagnosis, a life expectancy of six months or less, and who would not be seeking further treatment.
2. Clients would be followed by a Shore Home Health and Hospice Agency nurse who would provide nursing oversite.
3. Any client not followed by a Shore Home Health and Hospice nurse will be followed by a Hospice House primary registered nurse case manager.
4. Hospice House would not accept clients who would fall outside of the parameters established for the skill level of the volunteer caregivers e.g. compromised Alzheimer clients
5. The majority of the volunteer caregivers would consist of unlicensed personnel.

You stated at this time the pool of volunteer caregivers/significant others has not been built up and therefore Hospice House shall open with some paid staff including Donna Stone, Guest Wing Manager, who is also a Home Health Aide with extensive experience in Hospice care.

You stated that Shore Home Health and Hospice has indicated to you that their usual standard of care is to teach one family member how to perform a nursing function and that family member in turn, teaches the remaining family members how to perform that nursing function, e.g. turning and position, etc. You state that Hospice House is hoping that this same standard of care could be employed by Shore Home Health and Hospice nurses with the Hospice House volunteer caregivers who serve as a significant other. For example, a Shore Home Care Nurse who is serving as a case manager would teach the volunteer caregiver to suction a client's oral/pharyngeal airway and in turn that unlicensed volunteer caregiver of Hospice House, would teach the next shift of unlicensed volunteer caregiver how to suction the client's oral pharyngeal airway given that each volunteer caregiver had completed a Hospice House Training program which would include the routine skills necessary to care for the Hospice House client population.

Given this conceptual framework, the following reflects our discussion.

1. The role of the primary case manager is the responsibility of a registered nurse, who may be either a volunteer or a paid employee. A licensed practical nurse may assist but may not assume the role of primary case manager for any clients.
2. In regard to the statement that there is no requirement for Hospice House to employ a nurse consultant, please be advised that the Board of Nursing would not require Hospice House to employ a nurse consultant. The Board's requirement is, that a registered nurse must serve as the primary case manager for any client of Hospice House due to the nursing functions being performed in this setting for this population. Should Licensing and Certification Administration, or the community at large, or the Medical Director or Shore Home Health and Hospice believe that it would be reasonable and prudent for Hospice House to employ a nurse consultant then that may be the course of action that the Hospice House may wish to take.
3. Registered nurses and licensed practical nurses may delegate to unlicensed persons selected nursing functions. The nursing functions which may be delegated are based upon the licensed nurses' assessment of the individual client in terms of the client's degree of chronicity and stability; the degree of predictability of the client's response to the task being performed; and, the routine nature of the task to be performed e.g. the task is performed in the same series of sequential steps for each client. In addition, a licensed nurse who chooses to delegate to an unlicensed person is held to instructing, and/or verifying the unlicensed person's knowledge, skill and competency in the performance of the task to be delegated; and, in addition is held accountable to regularly monitor, supervise and evaluate the unlicensed person in the performance of the act. In addition, the nurse is held accountable for rectifying the situation when the individual performs the

delegated act incorrectly (e.g. remediation or reteaching) and, the nurse is prohibited from continuing to delegate the task to an unlicensed person who consistently demonstrates incompetency in the performance of the delegated nursing function (e.g. the volunteer caregiver is unable to perform the task). When a nurse complies with the Delegated Nursing Functions Regulations and meets the burden of instructing, verifying, supervising and evaluating the unlicensed person's performance of the delegated task, then the nurse may choose to delegate selected nursing tasks to unlicensed persons (this is in contrast to your misunderstanding that an unlicensed person may do whatever a nurse may choose to delegate).

4. I would take issue with your point that a nurse who delegates a nursing task has no legal jeopardy when he or she meets the standard for delegation. The licensed nurse is always accountable for his/her action/lack of action. However, the licensed nurse meets the standard for delegation as referenced in COMAR 10.27.09 and COMAR 10.27.10, Professional Competency (.03(A)(2) then the nurse has demonstrated prudent practice in exercising their professional judgment to delegate,(e.g. instructing, verifying, monitoring, supervising etc. as referenced in item one).

5. Licensed nurses may delegate those treatments which are of a routine nature for the patient population they are serving. It would be reasonable and expected that there would be selected activities of daily living that many of the hospice clients would routinely require assistance with. These routine activities are as you described in your letter and may include but are not limited to: bathing, dressing, turning and positioning, feeding, transfer from bed to chair, etc. It is appropriate and expected that Hospice House would generate policies and procedures which clearly address the activities of daily living which may be performed by the volunteer caregiver of Hospice House; and, how these specific activities are to be performed. It would be reasonable, appropriate and expected that all Hospice House volunteer caregivers receive education and training in these activities of daily living. In addition, prior to the staff person performing any of these activities independently it would be necessary for each staff person to be evaluated for clinical competency. The oversight for the training for these activities of daily living would best be supervised by a registered nurse. However a variety of other staff, including unlicensed persons, can be utilized to conduct the training.

6. Any and all nursing functions e.g. external catheter care, medication administration, etc must be taught be a registered nurse. Again, the standard that the volunteer caregiver/significant other would be held to, is the demonstration of clinical competency prior to performing the delegated nursing function independently.

7. In regard to the administration of medications, the statements that you have shared relative to The Delegated Nursing Functions Regulations COMAR 10.27.11.05 are incorrect. These regulations **PERMIT** a licensed nurse to delegate to an unlicensed person selected aspects of medication administration which include: the administration of medication by way of a gastrostomy tube or rectal tube; administration of oral medication if the nurse has calculated the dosage; administration of medication by way of subcutaneous injection if the nurse has calculated the dosage; and, administration of

8. medication by inhalant dispenser if it has been prepared by a pharmacist or authorized prescriber. These regulations also **PROHIBIT** a nurse from delegating to an unlicensed person: the calculation of any medication dose; administration of medication by intravenous route; administration of medication by injection other than a subcutaneous as referenced above; administration of medication by way of a tube inserted into a cavity of the body; and, administration of medications used for intermittent positive pressure breathing or other method involving medication inhaled treatment.

9. Hospice House's plan for developing policies, procedures, and a training program for the administration of medications by volunteer unlicensed staff persons is reasonable, appropriate, and in compliance with COMAR 10.27.11.05(F) . I understand that this plan includes always having a shift supervisor who has completed the medication course and who has demonstrated competency in the administration of medications. Please be advised that only volunteer caregivers who have passed the medication training program and who have demonstrated clinical competency in medication administration may administer medications, including PRN and narcotics. In addition, only a Registered nurse may fill a medi-planner for use for a Hospice House client. However, once the registered nurse has done so, the volunteer care provider who has met the requirements as stated above for medication training and competency, may administer these pre-poured medication.

9. In summary, I would state that given the framework that Shore Home Health and Hospice has stated regarding the standard of care for family members which is: the registered nurse teach one family member to perform a delegated nursing function and that family member in turn teach other family members to perform the nursing function, it is recommended that Hospice House:

    1. obtain a letter from Shore Home Health Care and Hospice stating that this is their usual standard of care;

    2. obtain a signed statement from each client who is admitted, that the client is aware that all caregivers are volunteers who serve as the client's significant other/surrogate family member; and,

    3. obtain from the client, an acknowledgment that, as there is no charge for the Hospice Care; and, that the caregivers are volunteers serving as the client's significant other, Hospice House is relieved of any liability.

Given this model of care, the registered nurse case manager can teach a nursing function, to an unlicensed volunteer caregiver and for that unlicensed volunteer caregiver in turn to then teach another unlicensed volunteer caregiver to perform that same nursing function using the same standard that you have referenced in your letter .

I hope that this helps to clarify our lengthy, complex, in-depth discussion. Thank you so much for understanding the time lag in my response. As I indicated in our recent telephone discussion I was out of the office until May 5, 1998 and this is the first opportunity I have had to respond to you. Should you have any questions in regards to this or any other nursing issue please do not hesitate to contact me at (410)764-5124.

Sincerely,

Barbara Newman

Barbara Newman, RN, MS
Nursing Practice Consultant

BN/dab

EXHIBIT B

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

April 27, 2009

Ms. Julie Crocker, Executive Director
Talbot Hospice Foundation
586 Cynwood Drive
Easton, MD 21601

PROVIDER # H141
RE: NOTICE OF RESULTS OF INFORMAL DISPUTE RESOLUTION

Dear Ms. Crocker:

You requested informal dispute resolution to address certain deficiencies cited during the survey completed at your facility on January 8, 2009. On April 15, 2009, we met with you to conduct the informal dispute resolution process.

During our meeting we discussed those issues which you had identified in your letter. After full consideration of the information which you provided, we have made the following decisions with respect to the issues you raised:

There was no information submitted to indicate that the findings should be changed, and the deficiencies will remain as written.

As you described in the meeting, Talbot has implemented the following programmatic changes subsequent to the January survey:

1. Talbot Hospice Foundation hired a Community Liaison registered nurse (RN) to provide a minimum of 16 hours of oversight and supervision of Certified Nursing Assistants (CNA) and Certified Medication Technicians (CMT) at the Guest Wing (hospice residence). This RN will assume the delegating nurse responsibilities for nursing care performed by the CNAs and CMTs.

2. Talbot Hospice Foundation will implement new Guest Wing admission procedures, including patient assessment and Guest Wing care plan development.

The admission process will be a coordinated effort between Talbot Hospice Foundation and Shore Home Care Hospice.

3. Talbot Hospice Foundation will implement new clinical record procedures, including securing patient specific documents from Shore Home Care Hospice and initiating the use of new clinical documentation forms.

4. Talbot Hospice Foundation will clarify the responsibilities of Talbot Hospice Foundation and Shore Home Care Hospice regarding case management.

5. Talbot Hospice Foundation reviewed and revised policies for the Guest Wing and the Pathways program.

6. Talbot Hospice Foundation developed a broader quality improvement process regarding the nursing services provided by the Nurse Educator as described in the policy.

Based upon the information you presented at our meeting, which we have considered a presentation of Talbot's plan of correction, we have reviewed and accepted the plan of correction. Please be advised that an unannounced follow-up visit may occur prior to the next standard survey to confirm that these measures are fully implemented.

As we discussed, issues remain as to the status of Talbot as a limited hospice given the scope of services provide. You confirmed that while Talbot will assist patients in administering medication, Talbot does not accept individuals who require more involved nursing care, for example IVs, G-tubes, or any type of complex medical care. Under the specific circumstances discussed in our meeting and identified in this letter, given the unique history of Talbot, and based upon its established record of care, we are electing at this time not to pursue the licensure status issues. However, we do look forward to working with you to resolve the larger issues regarding the distinction between general and limited hospices.

Once again, thank you for taking the time to meet with us, and for Talbot's thoughtful response to the concerns identified during the survey. If you have any questions, please contact, Barbara Fagan, Program Manager at 410-402-8040.

Sincerely yours,

Wendy Kronmiller, Director
Office of Health Care Quality

cc: File II

EXHIBIT C

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL001213	A. BUILDING _____ B. WING _____	12/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUEST WING (THE)	586 CYNWOOD DRIVE EASTON, MD 21601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments On December 17, 2013, a pre-licensure survey was conducted for the purpose of determining the facility's compliance with the requirements of COMAR 10.07.14. Survey activities included policy review, observation of the environment, review of staff records, and interview with staff. The facility's census at the time of the survey was zero (0) residents. The facility was determined to be in compliance with the COMAR 10.07.14 Requirements For Assisted Living Facilities.	E 000		

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Molly Kirsch — TITLE: ALM — (X6) DATE: 12/17/13

EXHIBIT D

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein M.D., Secretary

August 11, 2011

Ms. Julie Crocker, Executive Director
Talbot Hospice Foundation
586 Cynwood Drive
Easton, MD 21601

RE: NOTICE OF COMPLIANCE WITH HEALTH COMPONENT REQUIREMENTS

Dear Ms. Crocker:

On August 3, 2011, a compliant investigation was conducted at your facility by the Office of Health Care Quality to determine if your agency was in compliance with State requirements for a Hospice provider.

This survey found that your facility is in compliance with the health component of the requirements.

Please sign and date the enclosed DHMH-767, and return it to me to complete the survey documentation. If you have any questions, please call me at (410) 402-8040 or by fax at (410) 402-8277.

Sincerely,

Barbara Fagan

Barbara Fagan, Program Manager
Office of Health Care Quality

Enclosure: DHMH-767

cc: File

State of Maryland
Department of Health and Mental Hygiene
Office of Health Care Quality

55 Wade Avenue
Catonsville, Maryland 21228

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(STATE REGULATIONS)

Nurses:
Dietitian:
Auditor:
Sanitarian:

Facility: Talbot Hospice Foundation
586 Cynwood Drive
Easton, MD 21601

Date of Visit: 8/3/11

Type: Hospice (Limited License)

STATE REGULATION	SURVEYOR FINDINGS	FACILITY PLAN OF CORRECTION	PROPOSED CORRECTION DATE
	A Limited License Hospice agency complaint investigation was conducted on August 3, 2011. Complaint Number: H141063011 The complaint investigation included: A review of the clinical record for the patient named in the complaint (A); a review of the complaint file; a review of an admission packet including the patient's bill of rights; and interviews with the complainant and agency's administrative and clinical staff. The complainant, spouse of the patient named in the complaint (Patient A), alleged violations related to the quality of care and treatment the patient received.		

SURVEYOR'S SIGNATURE DATE

JLC 8/15/11
FACILITY REPRESENTATIVE SIGNATURE DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(STATE REGULATIONS)

Nurses:
Dietitian:
Auditor:
Sanitarian:

Facility: Talbot Hospice Foundation
586 Cynwood Drive
Easton, MD 21601

Date of Visit: 8/3/11

Type: Hospice (Limited License)

STATE REGULATION	SURVEYOR FINDINGS	FACILITY PLAN OF CORRECTION	PROPOSED CORRECTION DATE
	The complainant's allegations were not substantiated. Additionally, no deficiencies related to the complaint were identified. The agency's administrative and clinical staff was kept informed of the investigation findings. The agency staff was given the opportunity to present information relative to the findings during the course of the investigation. An exit interview was conducted on August 3, 2011.		

DHMH 767
REVISED 2/00

SURVEYOR'S SIGNATURE DATE

JRC 8/15/11
FACILITY REPRESENTATIVE SIGNATURE DATE

EXHIBIT E

EXHIBIT E: REVENUES AND EXPENSES - PROPOSED PROJECT (8-28-14)						
	Projected Years					
CY	2015	2016	2017	2018	2019	2020
1. Revenue						
a. Inpatient services	$58,962	$66,346	$73,730	$81,115	$89,226	$98,149
b. Outpatient services	$1,369,101	$1,542,652	$1,716,202	$1,889,753	$2,078,728	$2,286,601
c. Gross Patient Service Revenue	$1,428,063	$1,608,998	$1,789,932	$1,970,868	$2,167,954	$2,384,750
d. Allowance for Bad Debt	($3,385)	($3,747)	($4,109)	($4,471)	($4,918)	($5,410)
e. Contractual Allowance	($11,392)	($13,556)	($15,720)	($17,884)	($19,672)	($21,639)
f. Charity Care	($14,240)	($13,332)	($12,424)	($11,515)	($12,666)	($13,933)
g. Net Patient Services Revenue	$1,399,046	$1,578,363	$1,757,679	$1,936,998	$2,130,698	$2,343,768
h. Other Operating Revenues (Specify)[1]	$300,000	$306,900	$313,959	$321,180	$327,604	$334,156
i. Net Operating Revenue	$1,699,046	$1,885,263	$2,071,638	$2,258,178	$2,458,302	$2,677,924
2. Expenses						
a. Salaries, Wages, and Professional Fees, (including fringe benefits) [2]	$1,086,849	$1,111,847	$1,137,419	$1,163,580	$ 1,190,343	$ 1,217,721
b. Contractual Services	$142,024	$159,309	$176,594	$193,880	$ 211,778	$ 230,522
c. Interest on Current Debt	$	$	$	$		
d. Interest on Project Debt	$	$	$	$		
e. Current Depreciation	$	$	$	$		
f. Project Depreciation	$	$	$	$		
g. Current Amortization	$	$	$	$		
h. Project Amortization	$	$	$	$		
i. Supplies	$302,303	$334,384	$366,465	$398,546	$ 433,008	$ 469,439
j. Other Expenses (Specify)	$228,139	$233,462	$238,785	$244,109	$ 248,991	$ 253,971
k. Total Operating Expenses	$1,759,315	$1,839,002	$1,919,263	$2,000,115	$ 2,084,120	$ 2,171,653
3. Income						
a. Income from Operation	($60,269)	$46,261	$152,375	$258,063	$374,182	$506,271
b. Non-Operating Income	$	$	$	$		
c. Subtotal	($60,269)	$46,261	$152,375	$258,063	$374,182	$506,271
d. Income Taxes	0	0	0	0		
e. Net Income (Loss)	($60,269)	$46,261	$152,375	$258,063	$374,182	$506,271

[1]Endowment income, donations.
[2]Excluding development staff.

EXHIBIT F

MARYLAND
HEALTH CARE
COMMISSION

COMAR 10.24.13: Supplement Tables

State Health Plan for Facilities and Services: Hospice Services Chapter

Statistical Data Tables

DRAFT: INFORMAL PUBLIC COMMENTS DUE MAY 10, 2013

Table 8

Maryland Hospice Need Projections[1]:
Base: 2011 Target: 2016

		Baseline Use Rate[2]	Target Use Rate	Target Year Deaths	Gross Need	Target Year Capacity	Net Need	Volume Threshold	Net Need Exceeds Volume Threshold
		2011	2016	2016	2016	2016	2016	2016	2016
Central Maryland	Anne Arundel County	0.47	0.45	3,825	1,729	2,308	-579	262	No
	Baltimore City	0.25	0.45	5,823	2,632	1,579	1,053	262	Yes
	Baltimore County	0.54	0.45	7,510	3,394	6,415	-3,021	262	No
	Harford County	0.41	0.45	1,863	842	1,007	-165	262	No
	Howard County	0.42	0.45	1,514	684	766	-82	262	No
Eastern Shore	Caroline County	0.18	0.45	300	135	29	106	262	No
	Cecil County	0.54	0.45	848	383	681	-298	262	No
	Dorchester County	0.19	0.45	367	166	63	103	262	No
	Kent County	0.31	0.45	225	102	98	4	262	No
	Queen Anne's County	0.44	0.45	393	178	258	-80	262	No
	Somerset County	0.38	0.45	258	116	211	-95	262	No
	Talbot County	0.39	0.45	416	188	184	4	262	No
	Wicomico County	0.44	0.45	875	396	537	-141	262	No
	Worcester County	0.42	0.45	593	268	411	-143	262	No
Montgomery County	Montgomery County	0.43	0.45	5,805	2,624	3,158	-534	262	No
Southern Maryland	Calvert County	0.35	0.45	625	283	247	36	262	No
	Charles County	0.29	0.45	925	418	366	52	262	No
	Prince George's County	0.22	0.45	4,946	2,235	1,151	1,084	262	Yes
	Saint Mary's County	0.47	0.45	697	315	318	-3	262	No
Western Maryland	Allegany County	0.22	0.45	875	395	221	174	262	No
	Carroll County	0.53	0.45	1,376	622	1,021	-399	262	No
	Frederick County	0.34	0.45	1,621	733	699	34	262	No
	Garrett County	0.3	0.45	296	134	94	40	262	No
	Washington County	0.38	0.45	1,421	642	674	-32	262	No

(1) Data Sources: Hospice utilization data is from on the MHCC Annual Maryland Hospice Survey; Mortality data is from by the Maryland Vital Statistics Administration; Population data is from the Maryland Department of Planning.

(2) Baseline Use Rate is for reference purposes only. It is not used for the calculation of Hospice Need.

Table last revised on 2/19/13